TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Carlos Kugler, M.D.

Respondent Name
Mitsui Sumitomo Insurance Company of America

MFDR Tracking Number
M4-17-2401-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CERTIFYING EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein. This is a fee schedule reduction."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2016	Examination to Determine Maximum Medical Improvement and Impairment Rating	$450.00	$450.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating provided on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - ORC – See Additional Information: @ MMI / IR ROM 3 Areas
   - P12 – Workers' Compensation State Fee Schedule Adj

Issues

Is Carlos Kugler, M.D. entitled to additional reimbursement for the disputed services?

Findings

Dr. Kugler is seeking an additional reimbursement of $450.00 for an examination to determine maximum medical improvement and impairment rating for six body areas. Dr. Kugler was selected by the treating doctor to act in place of the treating doctor for this examination.

Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the MAR for this examination is $350.00.

28 Texas Administrative Code §134.250(4) states:

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
  (i) Musculoskeletal body areas are defined as follows:
    (I) spine and pelvis;
    (II) upper extremities and hands; and,
    (III) lower extremities (including feet).
  (ii) The MAR for musculoskeletal body areas shall be as follows.
    (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
    (II) If full physical evaluation, with range of motion, is performed:
      (-a-) $300 for the first musculoskeletal body area; and
      (-b-) $150 for each additional musculoskeletal body area.

(D) …
  (i) Non-musculoskeletal body areas are defined as follows:
    (I) body systems;
    (II) body structures (including skin); and,
    (III) mental and behavioral disorders.
  (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
  (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

Review of the submitted documentation finds that Dr. Kugler performed impairment rating evaluations and performed a full physical evaluation with range of motion for the spine, shoulders, and hips. Dr. Kugler also performed impairment ratings for the chest, anemia, and hernias. Total reimbursement is calculated as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine/Pelvis	$300.00
IR: Thoracic Spine (ROM)			
IR: Lumbar Spine (ROM)			
IR: Left Shoulder (ROM)	Musculoskeletal System	Upper Extremities	$150.00
IR: Right Shoulder (ROM)			
IR: Left Hip (ROM)	Musculoskeletal System	Lower Extremities	$150.00
IR: Chest	Respiratory System	Body Systems	$150.00
IR: Anemia	Hematopoietic System	Body Systems	$150.00
IR: Hernia	Digestive System	Body Systems	$150.00
Total MMI			**$350.00**
Total IR			**$1,050.00**
Total Exam			**$1,400.00**

The total reimbursement allowed is $1400.00. Mitsui Sumitomo Insurance Company of America reimbursed $950.00. An additional reimbursement of $450.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $450.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $450.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	June 9, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.